

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155483	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 07/11/2014
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NAME OF PROVIDER OR SUPPLIER WATERS OF RISING SUN THE	STREET ADDRESS, CITY, STATE, ZIP CODE 405 RIO VISTA LN RISING SUN, IN 47040
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F000000	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey Dates: July 7, 8, 9, 10 and 11, 2014</p> <p>Facility number: 000405 Provider number: 155483 AIM number: 100273800</p> <p>Survey team: Julie Dover RN, TC Angela Halcomb RN Rita Bittner RN Tammy Forthofer</p> <p>Census bed type: SNF/NF: 46 Total: 46</p> <p>Census payor type: Medicare: 7 Medicaid: 35 Other: 4 Total: 46</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality Review completed on July 18, 2014, by Brenda Meredith, R.N.</p>	F000000	<p>Preparation and/or execution of this plan of correction in general, or this corrective action in particular, does not constitute an admission of agreement by this facility of the facts alleged or conclusions set forth in this statement of deficiencies. The plan of correction and specific corrective actions are prepared and/or executed in compliance with State and Federal Laws.</p> <p>Facility is requesting paper compliance for all deficiencies in this POC.</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F000157 SS=D	<p>483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).</p> <p>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p>	F000157	F_157D Notify of change The	08/01/2014

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	<p>Based on record review, interview and observation, the facility failed to notify the physician of undocumented skin tears. This affected 3 of 3 residents reviewed for undocumented skin tears. (Resident's #63, #32, #14) Findings include:</p> <p>1. On 7/8/14 at 9:18 a.m., Resident #63 was observed to have a healing skin tear with a scab on right forearm. Resident #63 was observed to have three steri strips over skin tear.</p> <p>The clinical record for Resident #63 was reviewed on 7/8/14 at 2:30 p.m. The diagnoses included, but were not limited to, acute and chronic respiratory failure, obstructive chronic bronchitis with exacerbation, pneumonia and diabetes. Resident #63's weekly skin sheet, dated 6/9/14, indicated no skin tears or open area. This is the only skin assessment noted in Resident #63's chart.</p> <p>Resident #63's chart lacked documentation that the physician was notify of the skin tear.</p> <p>During an interview on 7/9/14 at 1:30 p.m., RN #1 indicated she was not aware Resident #63 had a skin tear on his arm.</p>		<p>facility's intent is to notify the family when a resident has a change of condition. ACTIONS TAKEN: Residents #63, #14, and #32 skin tears were immediately addressed and treated Each of the above resident's physicians and family/responsible party's notified, documentation completed, and careplans updated OTHERS IDENTIFIED: A 100% audit of Resident Skin Assessments completed at the time of the occurrence. No others affected. Residents #63, #14, and #32 physician and treatment orders were reviewed and made aware of to the staff. All residents will have weekly skin checks per policy. MEASURES TAKEN: Nurses were in-serviced on the following policies: Treatment of Skin Tears, Skin Conditioning Monitoring, and Physician Notification of Resident Change of Condition HOW MONITORED: The DON or her designee will monitor all incident reports and change of condition reports to ensure proper notification was given The DON or her designee will utilize the Incident Reporting Audit Tool daily for 4 weeks, then weekly times 4 weeks, then every two weeks times two months, then quarterly thereafter until 100% compliance is obtained and maintained. The Administrator will review all audits weekly. Any inconsistent results will be immediately clarified and corrected appropriately. Results</p>	

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	<p>During an interview on 7/9/14 at 1:35 p.m., Resident #63 indicated he did not remember when and how he got the area on his arm. Resident #63 indicated the nurse came in and put strips of tape on his arm.</p> <p>During an interview on 7/9/14 at 1:40 p.m., the Director of Nursing (DON) indicated she was not aware of resident having a skin tear and she had taken Resident #63 to the bathroom several times today. She indicated she had not notice a skin tear on his arm.</p> <p>During an interview on 7/9/14 at 2:20 p.m., the DON indicated she went to Resident #63's room and talked to him. Resident #63 indicated that he remembered bumping his arm and the nurse came in a placed pieces of tape on his arm, but he does not remember when it happened.</p> <p>The policy and procedure, obtained from the Director of Nursing, on 7/10/14 at 9:50 a.m., dated 04/06, indicated, "The attending physician will be notified of a change in a resident's condition by licensed personnel as warranted: ...1. Physician notification is to include but is not limited to: ...d. Any accident or incident, with injury. 2. Make an entry into Nurse's notes regarding</p>		will be monitored and reviewed at the monthly and quarterly QA Meeting for determination of ongoing monitoring This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of completion is: August 1, 2014.	

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	<p>condition/physician notification/physician's orders."</p> <p>2. During an observation on 7/7/2014 at 2:30 p.m., Resident #14 had five open areas on the bridge of her nose each consisting of 1/8th of an inch.</p> <p>During an interview on 7/7/2014 at 2:32 p.m., Resident #14 indicated no treatment or options for treatment of the five sore open areas were address by the facility. The resident indicated the open areas were from her recent surgery and appeared when the tape was removed for eye drops to be administered.</p> <p>The clinical record was reviewed on 7/09/2014 at 1:40 p.m. A physician's note indicated Resident #14 had a consultation for Cataract Surgery 6/25/2014 and Cataract Surgery on 7/1/2014. There was no documentation to indicate the physician had been notified of the skin condition on the resident's nose. The nursing notes from 7/1/2014 through 7/10/2014 indicated no change in Resident #14's skin condition.</p> <p>During an interview on 7/9/2014 at 1:45 p.m., LPN #17 indicated she was not aware of the skin tears across Resident #14's nose. LPN #17 indicated she was only aware of the resident receiving eye drops for the recent cataract surgery.</p>			

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	<p>LPN #17 indicated there was no documentation in the resident's chart concerning the skin abrasions.</p> <p>3. During an interview with and observation of Resident #32 on 07/07/2014 at 2:13: p.m., three steri strips were on the resident's right forearm. Resident #32 indicated he got his arm caught on a CNA's ring this morning while getting dressed.</p> <p>The clinical record was reviewed on 07/09/2014 at 10:58 a.m. The quarterly Minimum Data Set assessment (MDS), dated 05/14/2014, indicated a Brief Interview for Mental Status (BIMS) score of 15, which indicated no cognitive impairment. There was no documentation in the Progress Notes of acknowledgement of the skin tear.</p> <p>During an observation and interview with Resident #32 on 7/09/2014 at 2:14 p.m., it was noted the steri strips were no longer there. The resident indicated the steri strips fell off on their own. He denied any pain at the site.</p> <p>During an observation and interview on 7/10/2014 at 8:15 a.m., Resident #32 was sitting in a chair, the skin tear was open to air.</p> <p>During an interview on 07/10/2014 at</p>						

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F000225 SS=D	<p>10:53 a.m., Resident #32 indicated the incident occurred between 6:00 a.m. and 7:00 a.m. on 7/7/2014, while CNA (Certified Nurse's Aide) #2 helped him get dressed. Resident #32 indicated the skin tear was looked at by RN #3 at the time of the occurrence, who applied steri strips to it.</p> <p>During an interview on 07/10/2014, at 10:08 a.m., RN#1 indicated she did not know Resident #32 had a skin tear. RN #1 went to the Director of Nursing (DON) to find the report about the skin tear. She indicated no report was filed nor had the doctor been notified of the resident's change of condition at the time of the occurrence.</p> <p>3.1-5(a)(3)</p> <p>483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.</p>			

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	<p>The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p> <p>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>Based on record review and interview, the facility failed to ensure an allegation of verbal and physical abuse was reported to the Indiana State Department of Health (ISDH) for 1 of 21 residents interviewed for abuse. (Resident #7)</p> <p>Findings include:</p> <p>During an interview on 7/8/2014 at 12:52 p.m., Resident # 7 indicated she felt verbally abused by a staff nurse last Saturday evening. Resident #7 indicated she called the police department due to</p>	F000225	F_225D Reporting requirements of Abuse Allegations The facility's intent is to ensure all allegations of abuse are immediately reported to state officials in accordance with State and Federal Laws. ACTIONS TAKEN: Resident #7 could have been affected. An Initial Report of Alleged Abuse was submitted to the ISDH on July 9, 2014. After a thorough investigation, a follow-up report was submitted on July 12, 2014 with no findings. OTHERS IDENTIFIED: A 100% audit completed at the time of the occurrence. No others affected.	08/01/2014

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	<p>staff not answering her call light. Resident #7 indicated the staff could be heard in the hall way and would not come into her room. After resident #7 called the police department the resident indicated the floor nurse came into her room and leaned down into her face and said "you J--- A-- you need to use your call light."</p> <p>During an interview on 7/8/2014 at 1:14 p.m., Resident #7 indicated one of the CNA's was rough with her room mate. Resident #7 indicated she advised the CNA her roommate was a person too and the CNA's should not be rough with her. Then Resident #7 indicated the CNA implied to Resident #7 that she hurt her feelings. Resident #7 indicated she then reported the incident to the floor nurse and the nurse replied she would see what she could do about the CNA. Resident #7 indicated she could not remember the name of the nurse or CNA involved.</p> <p>The clinical record for Resident #7 was reviewed on 7/8/2014 at 2:40 p.m. A form titled, Referral / Assessment / Determination form, dated 6/29/2014, indicated the reason for the referral was verbal abuse was "yells/screams at others, curses at others." The form indicated Resident #7 "called 911 stating she wasn't being cared for." The form was</p>		<p>The facility, on two separate occasions (July 9 and July 10, 2014), interviewed all alert and oriented residents allowing the residents to report any mistreatment, neglect or abuse. No findings were reported by the residents. MEASURES TAKEN: Abuse and Abuse reporting procedure In-services were provided to all the staff, including the Administrator. With each alleged abuse/mistreatment reported, the facility will continue to immediately report and investigate per the Federal and State guidelines. HOW MONITORED: All alleged reports of abuse/mistreatment will be immediately reviewed by the Administrator and Director of Nursing ensuring the first report was submitted timely. All reports and investigations will be discussed at daily morning meetings. Results will be monitored and reviewed at the monthly and quarterly QA Meeting for determination of ongoing monitoring. This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of completion is: August 1, 2014</p>				

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	<p>signed by the Administrator on 6/30/2014 at 8:00 a.m. The documentation in Nurse's Notes indicated Resident #7 had called 911 on the evening of 6/29/2014, and told dispatch that she wasn't being cared for.</p> <p>The Minimum Data Set (MDS) Quarterly assessment for Resident #7, dated 6/6/2014, indicated he resident had a BIMS (Brief Interview for Mental Status) score of 15 (cognitively intact), had no behaviors, and was a one person physical assist.</p> <p>The Nurse's Note, dated 6/26/2014, and signed by the Director of Nursing (DON), indicated she had spoken with Resident #7 regarding her phone call to 911 the previous evening. The DON indicated Resident #7 indicated she called 911 because she needed to go to the bathroom and no one had come to take her. The DON's documentation in the Nurse's Notes indicated Resident #7 had indicated she should not have to use her call light that staff should know when the resident has to go to the bathroom.</p> <p>The Social Service Notes, dated 6/26/14, indicated the Social Service Director spoke with Resident #7 concerning the 911 call the previous night. The documentation indicates Resident #7</p>			

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	<p>indicated no one would come to help her. Social Service Director indicated he educated the resident on the importance of using her call light.</p> <p>During an interview on 7/9/14 at 9:59 a.m., the Social Service Director indicated he came into work on 6/30/14, and spoke with Resident #7 concerning the 911 call. The Social Service Director indicated Resident #7 had indicated she wanted help to get out of the chair and didn't use her call light. Social Service Director indicated the call light was within reach and functioning. Social Service Director indicated Resident #7 never mentioned anything concerning verbal abuse on 6/30/14. The Social Service Director indicated he was aware of Resident #7 not using her call light for the past month. Social Service Director indicated there had not been any care planning concerning Resident #7's use of the call light. The Social Service Director indicated the staff had talked about care planning the issue of Resident #7 refusing to use her call light. The Social Service Director indicated he had spoken with Resident #7 concerning her language with staff and had not documented the occurrences. The Social Service Director indicated he did not feel the occurrences were a major issue. The Social Service Director indicated he did</p>			

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	<p>not know about Resident #7 claiming a nurse got into her face and used improper language.</p> <p>During a phone interview on 7/9/2014 at 10:29 a.m. Resident #7's daughter indicated her mother had complained about staff being a little rough with her. Resident #7's daughter indicated her mother did not express any concerns pertaining to verbal abuse. Resident #7's daughter indicated she had not spoken to the facility concerning her mothers comments.</p> <p>A policy and procedure for "ABUSE," with a revision date of 7/1/11, was provided by the Social Service Director on 7/8/14 at 2:40 p.m. The policy indicated, but was not limited to, "The facility will not condone abuse of any type by anyone including staff members, other residents, volunteers, family, legal guardians, friends, visitors or other individuals. Definitions of key terms: b) " Verbal Abuse; The use of oral, written, or gestured language that willfully includes disparaging and derogatory terms to residents or their families, or within their hearing distance, regardless of their age, ability to comprehend, or disability." Number 7 on the ABUSE policy indicated, "The facility will initiate at the time of any finding of potential</p>			

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F000226 SS=D	<p>abuse or neglect an investigation to determine cause and effect. Number 10 on the ABUSE policy indicated, "Suspected or substantiated cases of resident abuse, neglect, misappropriation of property, or mistreatment shall be thoroughly investigated and documented by the Administrator, and reported to the appropriate state agencies, physician, families, and / or representative as required by state guidelines."</p> <p>3.1-28(c)</p> <p>483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. Based on record review and interview, the facility failed to implement their abuse policy and procedure related to</p>	F000226	F_226D Reporting requirments of Abuse Allegations The facility's intent is to ensure all allegations of abuse are immediately	08/01/2014

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	<p>reporting for 1 or 1 residents who met the criteria for abuse. (Resident #7).</p> <p>Findings include:</p> <p>During an interview on 7/8/2014 at 12:52 p.m., Resident # 7 indicated she felt verbally abused by a staff nurse last Saturday evening. Resident #7 indicated she called the police department due to staff not answering her call light. Resident #7 indicated the staff could be heard in the hall way and would not come into her room. After resident #7 called the police department the resident indicated the floor nurse came into her room and leaned down into her face and said "you J--- A-- you need to use your call light."</p> <p>During an interview on 7/8/2014 at 1:14 p.m., Resident #7 indicated one of the CNA's was rough with her room mate. Resident #7 indicated she advised the CNA her roommate was a person too and the CNA's should not be rough with her. Then Resident #7 indicated the CNA implied to Resident #7 that she hurt her feelings. Resident #7 indicated she then reported the incident to the floor nurse and the nurse replied she would see what she could do about the CNA. Resident #7 indicated she could not remember the name of the nurse or CNA involved.</p>		<p>reported to state officials in accordance with State and Federal Laws. . ACTIONS TAKEN: Resident #7 could have been affected. An Initial Report of Alleged Abuse was submitted to the ISDH on July 9, 2014. After a thorough investigation, a follow-up report was submitted on July 12, 2014 with no findings. OTHERS IDENTIFIED: A 100% audit completed at the time of the occurrence. No others affected. The facility, on two separate occasions (July 9 and July 10, 2014), interviewed all alert and oriented residents allowing the residents to report any mistreatment, neglect or abuse. No findings were reported by the residents. MEASURES TAKEN: Abuse and Abuse reporting procedure In-services were provided to all the staff, including the Administrator. With each alleged abuse/mistreatment reported, the facility will continue to immediately report and investigate per the Federal and State guidelines. HOW MONITORED: All alleged reports of abuse/mistreatment will be immediately reviewed by the Administrator and Director of Nursing ensuring the first report was submitted timely. All reports and investigations will be discussed at daily morning meetings. Results will be monitored and reviewed at the monthly and quarterly QA Meeting for determination of</p>	

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	<p>The clinical record for Resident #7 was reviewed on 7/8/2014 at 2:40 p.m. A form titled, Referral / Assessment / Determination form, dated 6/29/2014, indicated the reason for the referral was verbal abuse was "yells/screams at others, curses at others." The form indicated Resident #7 "called 911 stating she wasn't being cared for." The form was signed by the Administrator on 6/30/2014 at 8:00 a.m. The documentation in Nurse's Notes indicated Resident #7 had called 911 on the evening of 6/29/2014, and told dispatch that she wasn't being cared for.</p> <p>The Minimum Data Set (MDS) Quarterly assessment for Resident #7, dated 6/6/2014, indicated he resident had a BIMS (Brief Interview for Mental Status) score of 15 (cognitively intact), had no behaviors, and was a one person physical assist.</p> <p>The Nurse's Note, dated 6/26/2014, and signed by the Director of Nursing (DON), indicated she had spoken with Resident #7 regarding her phone call to 911 the previous evening. The DON indicated Resident #7 indicated she called 911 because she needed to go to the bathroom and no one had come to take her. The DON's documentation in the Nurse's</p>		ongoing monitoring. This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of completion is: August 1, 2014				

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	<p>Notes indicated Resident #7 had indicated she should not have to use her call light that staff should know when the resident has to go to the bathroom.</p> <p>The Social Service Notes, dated 6/26/14, indicated the Social Service Director spoke with Resident #7 concerning the 911 call the previous night. The documentation indicates Resident #7 indicated no one would come to help her. Social Service Director indicated he educated the resident on the importance of using her call light.</p> <p>During an interview on 7/9/14 at 9:59 a.m., the Social Service Director indicated he came into work on 6/30/14, and spoke with Resident #7 concerning the 911 call. The Social Service Director indicated Resident #7 had indicated she wanted help to get out of the chair and didn't use her call light. Social Service Director indicated the call light was within reach and functioning. Social Service Director indicated Resident #7 never mentioned anything concerning verbal abuse on 6/30/14. The Social Service Director indicated he was aware of Resident #7 not using her call light for the past month. Social Service Director indicated there had not been any care planning concerning Resident #7's use of the call light. The Social Service</p>			

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	<p>Director indicated the staff had talked about care planning the issue of Resident #7 refusing to use her call light. The Social Service Director indicated he had spoken with Resident #7 concerning her language with staff and had not documented the occurrences. The Social Service Director indicated he did not feel the occurrences were a major issue. The Social Service Director indicated he did not know about Resident #7 claiming a nurse got into her face and used improper language.</p> <p>During a phone interview on 7/9/2014 at 10:29 a.m. Resident #7's daughter indicated her mother had complained about staff being a little rough with her. Resident #7's daughter indicated her mother did not express any concerns pertaining to verbal abuse. Resident #7's daughter indicated she had not spoken to the facility concerning her mothers comments.</p> <p>A policy and procedure for "ABUSE," with a revision date of 7/1/11, was provided by the Social Service Director on 7/8/14 at 2:40 p.m. The policy indicated, but was not limited to, "Suspected or substantiated cases of resident abuse, neglect, misappropriation of property, or mistreatment shall be thoroughly investigated and documented</p>			

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F000279 SS=E	<p>by the Administrator, and reported to the appropriate state agencies, physician, families, and / or representative as required by state guidelines."</p> <p>3.1-28(a)</p> <p>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under</p>			

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	<p>§483.10(b)(4). Based on observation, record review and interview, the facility failed to develop a comprehensive care plan for 4 of 4 residents reviewed for comprehensive care plans. (Resident's #63, #32, #14 and #7) Findings include:</p> <p>1. On 7/8/14 at 9:18 a.m., Resident #63 was observed to have a healing skin tear with a scab on right forearm. Resident #63 was observed to have three steri strips over skin tear.</p> <p>The clinical record for Resident #63 was reviewed on 7/8/14 at 2:30 p.m. The diagnoses included, but were not limited to, acute and chronic respiratory failure, obstructive chronic bronchitis with exacerbation, pneumonia and diabetes. Resident #63's weekly skin sheet dated 6/9/14, indicated no skin tears or open area. This was the only skin assessment noted in Resident #63's chart. Resident #63 chart lacked documentation of a skin care plan.</p> <p>During an interview on 7/9/14 at 1:30 p.m., RN #1 indicated she was not aware Resident #63 had a skin tear on his arm. During an interview on 7/9/14 at 1:35 p.m., Resident #63 indicated he did not</p>	F000279	<p>F_279D Develop comprehensive care plans The facility's intent is to develop a comprehensive care plan for each resident that includes measurable and objectives and timetables to meet a residents medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. ACTIONS TAKEN: Resident's #63, 14, and 32 were immediately assessed. Once orders were obtained from the physician, the care plan of each resident was updated to reflect the resident's change of skin condition. Resident #7's care plan was completed 7/1/2014 with the resident's family present. The IDT and family discussed resident's care including her language and refusal to use her call light to express her needs. Her care plan was immediately updated. OTHERS IDENTIFIED: All residents have the potential to be affected. 100% audit of Resident Skin Assessments completed at the time of the occurrence. No others affected. All residents will be audited for skin issues and any issues identified will be added to the resident's care plan. Care plans will continue to be reviewed and updated with any significant change of condition with each assessment. MEASURES TAKEN: The Care plan Development policy and procedure was reviewed with no</p>	08/01/2014			

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	<p>remember when and how he had gotten the area on his arm. Resident #63 indicated the nurse came in and put strips of tape on his arm.</p> <p>During an interview on 7/9/14 at 1:40 p.m., the Director of Nursing (DON) indicated She was not aware of resident having a skin tear. She indicated she had taken Resident #63 to the bathroom several times today and she did not notice a skin tear on his arm. The DON indicated there was no care plan for the skin tear.</p> <p>2. During an observation on 7/7/2014 at 2:30 p.m., Resident #14 had five open areas on the bridge of her nose each consisting of 1/8th of an inch.</p> <p>During an interview on 7/7/2014 at 2:32 p.m., Resident #14 indicated no treatment or options for treatment of the five sore open areas were addressed by the facility. The resident indicated the open areas were from her recent surgery and appeared when the tape was removed for eye drops to be administered.</p> <p>The clinical record for Resident #14 was reviewed on 7/09/2014 at 1:40 p.m. A physician's note indicated Resident #14 had a consultation for Cataract Surgery 6/25/2014, and Cataract Surgery on</p>		<p>changes made. The staff was in-serviced on the above procedure and the need to update care plans with any significant change of condition and with each assessment. HOW MONITORED: The DON and or her designee will monitor and discuss all resident changes of condition in morning meetings and ensure care plan is updated with any changes or significant issues. The Administrator will review all audits weekly. Any inconsistent results will be immediately clarified and corrected appropriately. Results will be monitored and reviewed at the monthly and quarterly QA Meeting for determination of ongoing monitoring. This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of completion is: August 1, 2014.</p>		

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	<p>7/1/2014. The Nurse's Notes indicated no change in Resident #14's skin condition. There was no Care Plan documentation for the change of condition or wound care across the bridge of resident #14's nose.</p> <p>During an interview on 7/9/2014 at 1:45 p.m., LPN #17 indicated she was not aware of the skin tears across Resident #14's nose. LPN #17 indicated she was only aware of the resident receiving eye drops for the recent cataract surgery. LPN #17 indicated there was no documentation in the resident's chart concerning the skin abrasions.</p> <p>3. During an interview on 7/9/14 at 9:59 a.m., Social Service Director indicated he came into work on 6/30/14 and spoke with Resident #7 concerning the 911 call. Social Service Director indicated Resident #7 indicated she wanted help to get out of the chair and didn't use her call light. Social Service Director indicated the call light was within reach and functioning. Social Service Director indicated Resident #7 never mentioned anything concerning verbal abuse on 6/30/14. Social Service Director indicated he was aware of Resident #7 not using her call light for the past month. Social Service Director indicated there had not been any care planning concerning Resident #7's use of the call</p>			

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	<p>light. Social Service Director indicated the staff had talked about care planning the issue of Resident #7 refusing to use her call light. Social Service Director indicated he had spoken with Resident #7 concerning her language with staff and had not documented the occurrences. Social Service Director indicated he did not feel the occurrences were a major issue.</p> <p>On 7/10/14 at 1:25 p.m., review of the care plan, dated 6/16/14, indicated Resident #7 had occasional incontinence with bowel and bladder weakness. and needed help with transfers. There was no documentation on the care plan related to refusal to use call lights. The Minimum Data Set assessment (MDS) quarterly assessment for Resident #7 on 6/6/14 indicated the resident was cognitively intact, required one person physical assist and had no behaviors.</p> <p>4. During an interview with and observation of Resident #32, on 07/07/2014 at 02:13: p.m., 3 steri strips were noted on right forearm. Resident #32 indicated he got his arm caught on a girls ring this morning when getting dressed.</p> <p>During an interview with Resident #32, on 07/10/2014 at 10:53 a.m., he</p>				

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	<p>indicated the incident occurred between 6 and 7 a.m. on 7/7/14, while CNA (Certified Nurse's Aide) #2 was helping resident to get dressed. Resident #32 indicated the skin tear was looked at by RN #3 at the time of the occurrence, who applied steri strips to it.</p> <p>Record review on 07/09/2014, at 10:58 a.m. of the quarterly Minimum Data Set (MDS), dated 05/14/2014, documented a Brief Interview for Mental Status (BIMS) score of 15, which indicated no cognitive impairment.</p> <p>On 7/11/14 at 12:08 p.m. a review of the progress notes, from 7/7/14 at 00:27 a.m. thru 7/10/14 at 10:26 a.m., indicated no acknowledgement of the skin tear.</p> <p>During an observation and interview with Resident #32, on 7/09/2014 at 2:14 p.m., it was noted the steri strips were no longer there. The resident indicated the steri strips fell off on their own. He denies pain at the site.</p> <p>During an observation and interview, on 7/10/14, at 8:15 a.m., Resident #32 was sitting in a chair, skin tear was open to air with no further treatment noted.</p> <p>During an interview, on 07/10/2014 at 10:08 a.m., RN #1 was unable to locate a</p>			

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F000371 SS=F	<p>care plan related to the skin tear.</p> <p>3.1-35(a)</p> <p>483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions</p> <p>A. Based on record review and observation, the facility failed to ensure sanitary measures were followed during 2 of 2 meal observations. This had the potential to affect 46 of 46 residents currently residing in the facility.</p> <p>B. Based on record review, observation and interview the facility failed to store, prepare, distribute, and serve food under sanitary conditions in that boxes and pots were stacked to the ceiling in the dry storage area, hands were not washed, clean and dirty dishes were sitting together, no dates on some foods in the freezer. There was food not covered on the steam table, no thermometer in one freezer and one refrigerator observed. Bucket filled with ice in the three compartment sink with dirty dishes in the other two compartments.</p>	F000371	F_371F Food procure, store/prepare/serve - sanitary The facility's intent is to ensure all food is stored, prepared, distributed and served under sanitary conditions. ACTIONS TAKEN: All nursing staff were in-serviced on hand washing and food tray service procedures, specifically related to buttering bread and handling food and drinks. All dietary and administration staff were in-serviced on hand washing. All dietary staff was in-serviced on food preparation, food storage, hand washing, glove usage, pot pan and supplies storage related to the fire code, trashcan lid procedures, thermometer usage in the freezer and fridge, and dirty utensils not to be near clean dishes. A new cooler with a lid replaced the ice bucket and was relocated to an area away from the three compartment sink. A butter roller has been ordered	08/01/2014

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	<p>Findings include:</p> <p>A. During initial dining observation on 7/7/14 at 12:10 p.m., the following was observed:</p> <p>CNA #8 was observed to butter Resident #25 bread with bare hands, CNA #8 was observed to give resident #12 a drink of water no hand washing or hand sanitizer was observed.</p> <p>CNA #9 was observed buttering Resident #1 bread touching bread with fingers. CNA #9 was observed to fold butter bread in half and hand Resident #1 her bread with bare hands, no hand washing or hand sanitizer observed.</p> <p>CNA #8 was observed to butter Resident #28 bread with bare hands then was observed to retrieved Resident #24 tray no hand washing or hand sanitizer was observed, CNA#8 buttered Resident #24 bread with bare hands.</p> <p>2. During a second dining observation on 7/9/14 at 12:04 p.m., the following was observed:</p> <p>CNA #10 was observed to butter Resident #42 bread with bare hands and then retrieved Resident #25 tray from the</p>		<p>allowing the kitchen staff to butter the residents bread. OTHERS IDENTIFIED: All residents have the potential to be affected. An audit of recent Infection Control logs and incident reports has been completed with no findings. MEASURES TAKEN: The Guidelines for Staff Preparing Food were reviewed with no changes. Nursing staff were in-serviced and demonstrated proficiency in serving and preparing food. Dietary staff has been in-serviced on hand washing, how to store, prepare, distribute and serve food under sanitary conditions. HOW MONITORED: The Dietary Supervisor or her designee will monitor food service, storage, preparation, and distribution to ensure sanitary conditions are met. The Dietary supervisor or her designee will utilize the "Kitchen/Food Service Observation Audit Tool" weekly for 4 weeks, then every two weeks times two months, then quarterly thereafter ensuring 100% compliance is obtained and maintained. The Audit tool will also include observing staff during mealtime 3 times per week rotating meals for 4 weeks, then two times a week for two months and quarterly thereafter ensuring 100% compliance is obtained and maintained. The Administrator will review all audits weekly. Any inconsistent results will be immediately clarified and</p>	

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	<p>food cart. CNA#10 was observed to butter Resident #25 bread no hand washing or hand sanitizer was observed.</p> <p>CNA #11 was observed to butter Resident #33 bread with bare hands then was observed to get another tray from the food cart with no hand washing or hand sanitizer observed.</p> <p>On 7/10/14 at 2:50 p.m., the Administrator provided Guidelines for Dining Servers, no date. "Clean Hands: Dirty hands or gloves spread germs/bacteria. Hands and fingernails should be washed thoroughly using the correct procedure that includes soap and warm water before work...between work tasks and any time the employee leaves and reenters the kitchen...the hands must be gloved during all times of food preparation and changes according to proper procedures...Gloves Used Correctly: Gloves are used anytime ready to eat foods must be touched by a hand...A bare hand is never to touch ready to eat foods...."</p> <p>B. On 7/7/14, during the initial tour of the dietary department, between 10:30 a.m. and 11:10 a.m., the following was observed:</p> <p>1. The dietary manager was observed to</p>		corrected appropriately. Results will be monitored and reviewed at the monthly and quarterly QA Meeting for determination of ongoing monitoring This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of completion is: August 1, 2014.	

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	<p>enter the kitchen without washing her hands, and then proceeded to open thickened cranberry juice.</p> <p>2. The Administrator entered the kitchen without washing his hands.</p> <p>3. The fridge and freezer lacked a thermometer on the inside to monitor temperatures.</p> <p>4. Individual ice cream in bowls with lids covering was observed in the freezer with no dates on them, an interview with the dietary manager stated the ice cream is for lunch.</p> <p>5. White bread in individual plastic bags were observed on the prep table no dates on the bread.</p> <p>6. An uncovered trash can with food smeared down the inside of the trash can was blocking the hand washing station. The trash can under the hand washing sink, was observed to have boxes and a trash can lid on top making it hard to open.</p> <p>7. The dry storage area was observed to have several boxes and steel pots sitting on the top shelf. The boxes and steel pots was observed too close to the ceiling. They are required to be a</p>			

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	<p>minimum of 18 inches from the ceiling.</p> <p>8. Dietary aid #12 was observed to wipe up spilled potato salad off the floor. The dietary aide #12 was observed to pour drinks for lunch no hand washing or hand sanitizer was observed.</p> <p>9. Cook #13 was observed to wash hands for 5 seconds then help dietary aid #12 finish pouring drinks for lunch.</p> <p>On 7/9/14 during second tour of the dietary department between 9:44 a.m. and 10:15 a.m., the following was observed:</p> <p>1. An uncovered trash can with smeared food down the side of the trash can was placed next to a prep table with clean dishes, on the same table with the clean dishes a dirty knife and dirty metal mixing bowl with white substance was observed on the table. The trash can under the hand wash station, observed to have boxes, plastic cup and used trashed on top of the trash can making it hard to open.</p> <p>2. The Administrator entered the kitchen without washing his hands, walked around the kitchen and then left without washing his hands.</p>				

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	<p>3. Dietary aid #16 was observed to wash hands for 7 seconds, apply disposable gloves, then started washing dirty dishes. Dietary aid#16 was observed to changed gloves and then started putting away clean dishes, no hand washing was observed.</p> <p>4. A dirty spoon was observed on a prep table next to clean bowls and cups.</p> <p>During another observation on 7/9/14 at 11:00 a.m., a bucket of ice was observed sitting in the three compartment sink, in the compartment next to the bucket of ice were dirty dishes and a bucket of dirty water.</p> <p>An interview with dietary aid #16 at the same time, she stated the ice will be used for ice water at lunch.</p> <p>On 7/9/14 at 11:07 a.m., cook #13 was observed to wash hands for 4 seconds, then started to temp foods for lunch. Cook #13 was observed to drop the thermometer gauge side in the puree green beans that she was holding onto with ungloved hands. Cook#13 retrieved the thermometer with another thermometer and rinsed it off in the three compartment sink with the dirty dishes, and went back to temp food on the steam</p>						

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	<p>table.</p> <p>On 7/10/14 at 2:50 p.m., the Administrator provided Guidelines for Staff Preparing Food, no date, "Clean Hands: Dirty hands or gloves spread germs/bacteria. Hands and fingernails should be washed thoroughly using the correct procedure that includes soap and warm water before work...between work tasks and any time the employee leaves and reenters the kitchen...the hands must be gloved during all times of food preparation and changes according to proper procedures...Gloves Used Correctly: Gloves are used anytime ready to eat foods must be touched by a hand...A bare hand is never to touch ready to eat foods..."</p> <p>On 7/10/14 at 2:50 p.m., the Administrator provided Guidelines for Staff Preparing Food, no date, "Clean Service: Handling utensils the wrong way may spread disease...Tableware is never handled by the area that makes contact with the food. The food contact part of any utensil or tableware is never touched with a bare hand. Clean Equipment: Food contact surfaces are sanitized before they are used with a cleaning cloth that is stored in a sanitizer solution between uses. Clean Food: Food may be infected by cough, sneezes,</p>			

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F000431 SS=E	<p>handling dirty equipment...It should be protected during storage, preparation, display and service...."</p> <p>3.1-21(1)(2)</p> <p>483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.</p> <p>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package</p>			

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	<p>drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>Based on observation, interview and record review, the facility failed to properly labeled in accordance with currently accepted professional principles, related to labeling of medications to assure they are provided to the resident accurately and in accordance with the prescribe's instructions for 4 out of 4 medication carts/ room observed. (Mulberry medication cart, Pin medication cart, treatment cart and medication storage room).</p> <p>Findings include:</p> <p>1. The Mulberry medication cart was observed, on 7/10/14 at 9:33 a.m., with RN #1. The medication labeled Major Antacids for Resident #4 had a pharmacy label with an expiration date of 4/30/14.</p> <p>During an interview, on 7/10/14 at 9:35 a.m., RN #1 indicated the medication labeled for Resident #4 showing an expiration date of 4/30/14, was currently being given and the expired bottle should have been removed and properly disposed of. RN #1 indicated there was a second bottle of the same medication in the bottom draw with current dating.</p>	F000431	<p>F_431E Drug records, Label/store drugs biological The facility's intent is to ensure to dispose of expired medications timely.</p> <p>ACTIONS TAKEN: Expired meds Labetatol and Major antacids were immediately removed and disposed of according to facility policy. OTHERS IDENTIFIED: 100% audit of all medication carts completed at the time of the occurrence. No others affected. All medications in the facility were immediately audited for appropriate labels and expiration dates. MEASURES TAKEN: The Medication Labeling and Storage policy was reviewed with no changes made. An In-service was completed with nursing staff regarding expiration dates of medications as well as removal of expired medications from the cart. HOW MONITORED: The DON or her designee will monitor the results of Medication and Treatment cart evaluations. Each cart will be evaluated every Sunday by the nurse on duty to ensure all medications are dated properly and any expired meds removed and disposed of according to facility policy. Pharmacy consultant will audit med carts quarterly. Any inconsistent results will be immediately clarified and corrected appropriately. Results will be monitored and reviewed at</p>	08/01/2014			

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	<p>2. The treatment cart was observed, on 7/10/14 at 9:42 a.m., with RN #1. A tube of Betameth Val ointment for Resident #44 was observed with no open date. The tube was flattened except for the last 1/8th of an inch out of a 4 inch tube. There was a second unopened tube stored in the same plastic bag as the used undated tube.</p> <p>During an interview, on 7/10/14 at 9:44 a.m., RN #1 indicated that the facility policy is all medication is to have an open date and the cream for Resident #44 should of been dated.</p> <p>3. The medication storage room was observed, on 7/10/14 at 9:51 a.m., with RN #1. An observation of the Stock cabinet on the bottom shelf of the top cabinet area was a vial of Labetalol with an expiration date of 6/27/14. This vial of Labetalol was for emergency supply use. Labetalol is used intravenously for a hypertensive emergency.</p> <p>During an interview, on 7/10/14 at 9:52 a.m., RN #1 indicated there was only one bottle of Labetlol in the emergency supply cabinet and that the expiration date on the pharmacy label was 6/27/2014. She indicated the manufacture expiration date was</p>		<p>the monthly and quarterly QA Meeting for determination of ongoing monitoring. This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of completion is: August 1, 2014.</p>				

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	<p>2/1/2015. RN #1 indicated that the vial of Labetlol was for the general population of residents for emergency use only.</p> <p>4. The Pin medication cart was observed, on 7/10/14 at 10:02 a.m., with LPN #14. Two medications were observed without open dates; Nasonex spray for Resident #28 had a open date label without any open date written, a vial of heparin for Resident #13 had no dispensed date or open date label.</p> <p>During an interview, on 7/10/14 at 10:03 a.m., LPN #14 indicated Resident #13 receives heparin three times a day. LPN #14 indicated the resident goes through the vials very quickly and the vials do not always get dated when opened. LPN #14 indicated the vials should of been labeled with an open date. LPN #14 indicated the resident takes one millimeter three times daily and a vial only holds ten millimeters.</p> <p>The Director of Nursing (DON) provided a copy of the facilities medication storage policy and procedure last updated 6/19/2012. Number 14 on the policy indicated, " Outdated, contaminated, or deteriorated drugs will be immediately withdrawn from stock. They will be disposed of according to drug disposal</p>			

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F000441 SS=D	<p>procedures, and reordered from the pharmacy if a current order exists."</p> <p>The DON provided a copy of the facilities drug labels policy and procedure last update 6/19/2012. Number 1 on the policy indicated "each prescription medication label includes: Date medication dispensed and expiration date."</p> <p>3.1-25(o) 3.1-25(k)(6)</p> <p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and</p>			

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	<p>corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. Based on observation, interview, the facility failed to ensure infection control practices were followed related to linen handling and hand washing for 3 of 3 staff observed. (RN #4, Housekeeper #5, PTA #6)</p> <p>Findings include:</p> <p>1. During observations of medication pass, on 7/7/14 at 11:47 a.m., RN #4 rubbed her face and scratched her head then without washing her hands or using hand gel she went to the clean supply closet and pick up a sleeve of medication cups. After returning to her medication cart RN #4 opened the medication cups</p>	F000441	<p>F_441D Infection Control, prevent spread, Linens The facility's intent is to ensure an effective Infection Control program is established to prevent the transmission of disease and infection. ACTIONS TAKEN: RN#4, Housekeeper #5, and PTA#6 were given an in-service on Safe Clean linen Handling and Hand washing. OTHERS IDENTIFIED: All residents have the potential to be affected. Linen handling and hand washing procedures were reviewed and demonstrated by RN#4, Housekeeper #5, and PTA #6. All staff (100%) will demonstrate linen handling and hand washing proficiency per facility policy by 8/1/2014. MEASURES TAKEN: The Linen</p>	08/01/2014

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	<p>and handled the stack of cups with her bare hands separating them between two of the three medication carts. Then RN #4 continued to restock the spoons on two of the three medication carts.</p> <p>During an observation, on 7/7/14 at 11:54 a.m., RN #4 without washing her hands or using hand gel picked up a spoon from the medication cart and mixed a residents medication into apple sauce. After mixing the apple sauce RN #4 started to walk towards the dinning room. On her way into the dinning room RN #4 drooped the spoon on the hallway floor three feet from the medication cart. She then picked up the spoon off of the floor and threw it away, without washing her hands or using hand gel RN #4 picked up another spoon and went into dinning room and administered the medication to a resident. While administering the medication to resident #14, RN #4 patted the residents hand and face then scratch her own nose and scalp prior assisting the resident back to her room. After walking the resident to her room RN #4 walked back to her medication cart, without washing her hands or using hand gel RN #4 picked up the glucometer out of the draw and walked back to Resident #14's room to test the residents BS. After RN #4 tested Resident #14 blood sugar RN #4 placed the glucometer into the</p>		<p>Handling and Hand washing procedures were reviewed with no changes made. The staff was in-serviced on the above procedures and the importance of safe handling of clean linen and hand washing. HOW MONITORED: The DON or her designee will conduct audits ensuring clean linen is handled safely and hand washing is performed correctly and appropriately. The DON or her designee will utilize the Linen Handling/Hand washing Audit Tool weekly for 4 weeks, then every two weeks times two months, then quarterly thereafter until 100% compliance is obtained and maintained. Any inconsistent results will be immediately clarified and corrected appropriately. Results will be monitored and reviewed at the monthly and quarterly QA Meeting for determination of ongoing monitoring. This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of completion is: August 1, 2014</p>		

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	<p>pocket of her jacket. RN #4 walked out of resident #14 room then walked directly to a Resident #48 room without washing her hands or using hand gel. After RN #4 left Resident #48's room at 12:13 p.m. RN #4 walked back to the nursing station and went to the sink and washed her hands for the first time since the initial observation at 11:47 a.m.</p> <p>During observation of staff carrying clean linens, on 7/7/14 at 11:12 a.m., Housekeeper # 5 carried clean linens against her shirt and pants into Resident #51 room. Housekeeper #5 used the clean linens to make Residents #51's bed.</p> <p>On 7/10/14 at 1:38 an observation of house keeper #5 while changing the bed linens for resident #44, Housekeeper #5 was holding the bed linens up against her clothing while unfolding the cover to be placed on Resident #44's bed.</p> <p>During observation on 7/10/14 at 1:40 PTA (Physical Therapy Aide) #6 went into the clean linen closet and took out a blanket then PTA #6 placed the lift sheet under her arm, holding the lift sheet between her side and arm, PTA #6 walked down the hallway to the therapy room. PTA #6 use the lift sheet to assist with Resident #41 positioning for therapy.</p>			

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	<p>During an interview, on 7/10/14 at 10:38 a.m., Housekeeping Director #7 indicated that all clean lines must be held away from the uniform and not lie directly against the staffs uniform.</p> <p>During an interview with the Director of Nursing (DON), on 7/11/14 at 9:00 a.m., the DON indicated the facility policy and procedure for hand washing follows The Center for Disease Control Guidelines.</p> <p>On 7/7/14 at 2:00 p.m., the Administrator provided the Handwashing policy and procedure, dated 7/1/11, and indicated the policy was the one currently used by the facility. GUIDELINE: It is the intent of facility to use proper handwashing technique to prevent the spread of infection as per Center of Disease Control Guidelines. RESPONSIBILITY: All staff. PROCEDURE: A: SOAP AND WATER: 1. Turn water on to comfortable temperature. 2. Moisten hands with water and apply soap. 3. Wash hands well for approximately 15 seconds to aid in the mechanical removal of bacteria... B. ALCOHOL-BASED HAND RUB 1. Apply alcohol-based hand rub to the palm of one hand. 2. Run hands together, covering all surface of hands and fingers until hands are dry. 3. Repeat with each resident contact...</p>			

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	<p>On 7/7/14 at 2:00 p.m., the Administrator provided the Standard Precautions policy, dated 7/1/11, and indicated the policy was the one currently used by the facility...PROCEDURE: Use Standard Precautions, or the equivalent, for the care of all patients. a. Handwashing. A. Handwashing. 1. Wash hands immediately after gloves are removed, between patient contacts, and when otherwise indicated to avoid transfer of microorganisms to other patients or environment. It may be necessary to wash hands between tasks and procedures on the same patient to prevent cross-contamination of different body sites.</p> <p>3.1-19(1) 3.1-19(2)</p>						
F000458 SS=D	<p>483.70(d)(1)(ii) BEDROOMS MEASURE AT LEAST 80 SQ FT/RESIDENT Bedrooms must measure at least 80 square feet per resident in multiple resident</p>						

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	<p>bedrooms, and at least 100 square feet in single resident rooms.</p> <p>Based on observation and interview, the facility failed to provide at least 80 square feet per resident for 2 of 27 resident rooms. (Rooms 5 and 7).</p> <p>Finding includes:</p> <p>During an environmental tour on 7/7/2014 at 2:15 p.m. with the Administrator the following rooms were observed to have less than 80 square feet per resident:</p> <p>Room 5 had 3 resident beds and was 217 square feet, equaling 72.33 square feet per resident.</p> <p>Room 7 had 3 resident beds and was 224 square feet, equaling 74.66 square feet per resident.</p> <p>The Administrator indicated they would use the beds if they got an admission.</p> <p>3.1-19(1) 3.1-19(2) 3.1-19(3) 3.1-19(4) 3.1-19(8)</p>	F000458	<p>F_458D Bedrooms Measure at least 80 SQ FT/Resident</p> <p>ACTIONS TAKEN A letter requesting a room waiver for rooms 5 and 7 was sent to Miriam Buffington, Enforcement Manager, Division of Long Term Care, in Indianapolis, Indiana on Thursday 7/24/2014</p>	08/01/2014